

Migrants' culture and religion impact on gender and implication for healthcare in Italy

Claudio Giovannini, Leuconoe Grazia Sisti*

Center for Global Health Research and Studies, Università Cattolica del Sacro Cuore, Rome, Italy

*Research performed during the PhD course at the Center for Global Health Research and Studies

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Summary. Foreigners living in Italy represent 9% of the total population of the country. They come from more than 200 different countries and profess religions for the most part different from the Catholic one, bringing with them behavioral models dependent both on religion and on the culture of their place of origin. Both those aspects, besides additional barriers immigrants may face (e.g., administrative and linguistic ones) may impact health and healthcare utilization. Thus, to fulfill the principles of the National Health Service (NHS) and offer effective and personalised care, the healthcare services are called upon to acknowledge those specificities and to address barriers to care they may represent. Among those aspects, gender – influenced both by religion and culture, as a whole – can influence factors such as the propensity to health-seeking behaviour or the relationship with health practitioners and thus generate discrimination and inequalities in unprepared health services. Our health workers also face new health challenges related to different cultures. Female genital mutilation and 'home-made' male circumcisions represent some of these issues. Proper training of health administrators and health workers is advisable to offer culturally sensitive health services that meet the universalist goal of our health system. Moreover, the development of this awareness and competence could be beneficial for the humanization of care, for all.

Key words. Gender, religions, immigration, healthcare workers, patient rights.

Introduction

Migration is globally recognised as a social determinant of health. Conditions experienced in the country of origin, during transit, and in the post-migration phase – such as poor living conditions, unstable and hazardous employment, discrimination, and barriers to accessing healthcare – expose immigrants to poorer health outcomes compared with native populations.¹

With regard to healthcare access, one of the major challenges posed by migration to receiving societies concerns the increase in religious pluralism and its cultural and institutional implications.

The immigrant population in Italy, due to its numerical size and cultural and religious diversity, represents

a significant challenge for public health planning and service delivery. In 2024 there were 5,308,000 foreign citizens residing in Italy (based on data from the National Institute of Statistics – ISTAT), to which an estimated additional 500,000 undocumented migrants must be added.² Compared with other European countries, migration to Italy shows several distinctive features: (i) its relatively recent development (approximately thirty years), (ii) the wide diversity of countries of origin (over 200 countries from all continents), (iii) the predominance of non-Catholic religious affiliations, and (iv) the strong connection migrants maintain with the religion and culture of their country of origin. The main countries of origin include Romania, Morocco, Albania, Ukraine, China, Egypt, India, Bangladesh, the Philippines, Pakistan, and Tunisia. Christians represent 52.9% of resident foreigners (29.1% Orthodox, 17% Catholic, 2.7% Evangelical, and 4.1% other Christian denominations). Muslims account for 29.8%, followers of Hinduism, Buddhism, Sikhism and other religions for 7.5%, while atheists represent 9.8%.

This diversity in countries of origin and religious affiliations poses challenges for healthcare planning and delivery. Each individual or group brings beliefs, values, traditions, and ways of thinking that differ not only from those of the host society but also among migrant groups themselves, depending on culture, country of origin, and religious faith. The spiritual and cultural expectations of immigrant patients, as well as religious ties, may therefore constitute barriers to accessing healthcare services and to effective interaction with healthcare professionals.

Culture of origin and religious faith tend to persist across generations, even when individuals are exposed to new social contexts. Religion, in particular, assumes a strong identity-building role for migrant populations. Migration often separates individuals from family and social networks in a traumatic manner, and religious communities in host countries frequently become key spaces for social interaction, mutual support, and cultural continuity. These dynamics reinforce the preservation of beliefs, values, and practices from the country of origin.

The 2030 Agenda for Sustainable Development and the international scientific community strongly call for universal access to quality healthcare, a commitment

further reinforced by the COVID-19 pandemic. In Italy, access to healthcare for immigrants is protected by one of the most inclusive legal frameworks in Europe, as guaranteed by Article 32 of the Constitution. Nevertheless, multiple obstacles continue to hinder effective access to services, including linguistic and cultural barriers, limited knowledge of the National Health Service (NHS), mistrust of an unfamiliar healthcare system, and difficulties in relationships with healthcare professionals.

Beyond legal and administrative barriers, gender represents one of the most significant determinants of healthcare access, articulated differently across migrant groups depending on cultural background and religious affiliation. Education level, economic conditions, and degree of social inclusion also play an important role. This article aims to provide an overview of the impact of culture and religion on gender, building on previous literature³ and on field expertise developed by our research centre over time.

How culture and religion affect gender differences and sexual and reproductive health

Culture, religion, beliefs and family contribute to the construction of gender patterns in all populations. Culture is a set of rules, knowledge, values, traditions, habits, beliefs, customs, artistic productions, shared by every individual forming part of a population. Within each culture, the construction of the role to be occupied by the individual in society is important. This includes the construction of gender roles, which occurs through a process that begins in childhood by assigning different patterns of behaviour, obligations and rights to the two biological sexes.

Religion plays a fundamental role in the construction of gender models in all populations and has determined, and still partly determines, the different placement of the two genders in societies. For the three major monotheistic religions (Judaism, Christianity and Islam), the construction of gender roles is based on Scripture. What all religions have in common is that they normatively assign women a subordinate and limited role, albeit with different motivations from time to time. Gender is declined in different ways in different cultures on the basis of gradually established norms that are functional in providing answers to specific socio-economic situations and which are changeable over time. In these answers, the intertwining of culture and religion to which society refers is always present, to the point that, even among different populations that follow the same religion, it leads to substantial differences in the set of obligations, rules, rights and duties reserved by society for the two sexes.

All religions have precise rules concerning the sexual sphere and reproduction. Sexuality, abortion and assisted reproduction follow precise rules dictated by the religion to which they belong.

Judaism obliges the man to procreate and not to disperse semen, while the woman may use contraceptives. Abortion is not permitted, but if it is intended to protect the physical or mental health of the woman, which could be damaged by a pregnancy, it may be permitted.⁴ In Jewish tradition, the fetus is protected from the moment of conception, but its right does not override that of the mother.⁵

Muslims are allowed to use temporary contraceptives, while permanent contraceptive methods (such as vasectomy and tubal ligation) are only permitted if the woman's health is at risk. For Islam, the fetus is considered alive after three months of gestation and therefore abortion after 120 days is not permitted unless the pregnancy poses a serious threat to the life of the mother, or in the case of fetal abnormalities.⁶

The Orthodox Church considers in vitro fertilisation procedures acceptable as a contribution to procreation in marriage, provided that all fertilised ova are used for implantation. Abortion is not permitted, not even in the case of fetal abnormalities, since the embryo is considered a living being from conception. However, it is accepted in the event of danger to the mother's life.⁷

For Hindus, life is considered extremely sacred and therefore birth control is considered a practice not to be encouraged and the only generally accepted form of contraception is moderation in sexual activity. Termination of pregnancy is therefore prohibited except in cases where there is a serious risk to the life of the mother.⁸

Sikhs are allowed to use contraception, but abortion is not accepted unless the mother's life is in danger, and assisted reproduction is only permitted during marriage.⁹ Generally, all Buddhist denominations condemn abortion and euthanasia, as human life is regarded as a favourable state of existence in which man has within himself the potential to awaken and achieve liberation.¹⁰

Gender and healthcare

Generally, different religious denominations present gender-specific challenges, which are further complicated by the intertwining with their culture of origin, making access to healthcare services and interaction with healthcare professionals more difficult.

For example, men may be reluctant to seek medical assistance even in serious conditions due to gender stereotypes and social norms that associate illness with weakness in relation to their gender role within the social group.¹¹ In some countries, Muslim patients generally do not accept being examined or treated by healthcare per-

sonnel of the opposite gender. Women, in particular, may be less willing to be examined by a male doctor. In addition to potentially refusing care from male healthcare personnel, there is often the practice of delegating medical communication to a male companion (father, husband, or brother), including the description of symptoms and approval of treatment. There have been reported cases, even in the news, of patients refusing care – even in emergencies – due to the absence of female health workers, thereby endangering the patient's life.

It is also well established that Hindu women prefer to be cared for and bathed only by female staff, and may wish to be examined by a doctor of the same sex. Hindu women are generally reluctant to visit a doctor and may only seek medical attention during late stages of pregnancy.⁸ They tend to be hesitant to expose parts of their body, so it is advisable to limit the area of examination and, if possible, conduct the visit in the presence of a husband or another family member.

Buddhist women prefer to be examined and cared for by female healthcare personnel, while monks are prohibited from receiving care from staff of the opposite sex. Often, women only seek medical attention at the end of pregnancy. Monks cannot be attended by female doctors, and hospitals in some Eastern countries have wards reserved exclusively for monks.¹⁰

Globally, migrant women face numerous challenges in accessing sexual and reproductive health (SRH) services¹¹ and are at higher risk of adverse maternal and neonatal outcomes. Beyond administrative, economic, and logistical barriers, health literacy, language, and cultural factors also play a significant role. In a recent systematic review including 28 studies worldwide, cultural differences were mentioned as barriers to seeking or receiving SRH care in 39% of the studies included. Main cultural obstacles included fear of modern methods and procedures, the absence of religious considerations in medical treatment, inability to be attended by female staff, and restrictions on performing cultural rituals after childbirth.¹²

Lack of information, stigma, religious and cultural practices, and insufficient attention to gender-specific needs within the healthcare system have also been reported as barriers to accessing mental health support in primary care among female migrants in Europe.¹³ Socio-cultural factors – including religious beliefs, family and social network dynamics, and medical mistrust – have been found to influence women's adherence to colorectal, breast, and cervical cancer screening.¹⁴

Also in Italy, immigrant women's adherence to breast and cervical cancer screening programs is lower than that of Italian citizens, as is their use of antenatal care¹⁵ and family planning counseling.

The migratory flows that have affected Italy in recent decades have also highlighted important issues for the

National Health Service concerning both sexes: non-therapeutic male circumcisions performed clandestinely ("home-made" circumcisions) and illegal practices such as female genital mutilation (FGM).

'Home-made' circumcisions

Male circumcision is practised worldwide for medical reasons, namely treating phimosis and paraphimosis, recurrent balanitis and balanoposthitis, and penile neoplastic diseases, as well as for hygienic and prophylactic purposes – particularly for HIV prevention¹⁶ but also for the prevention of HSV-2, HPV, and other infections¹⁷ and for religious and cultural reasons.

Latest data estimate a global prevalence of 38.7%, of which approximately half are for religious and cultural reasons.¹⁸

Regarding circumcision for non-medical reasons, ritual circumcision is primarily practised by Jews and Muslims (circumcision rates close to 100%), but it is also observed among Coptic Christians and Ethiopian Christians, as well as among sub-Saharan populations (e.g., Ghana, Nigeria, Kenya) who are both Christians and animists. In these communities, circumcision is performed as a religious ritual, a cultural tradition marking the transition to adulthood, and sometimes for infection prevention. Social desirability and acceptability also play a pivotal role in the Philippines and the Republic of Korea, and even in the US, alongside religious and prophylactic motivations.¹⁹

Focusing on religious circumcision among Jews, male circumcision is mandatory. It is linked to the covenant between God and Abraham (Genesis 17:10-14), with circumcision serving as the physical sign of this pact, repeated across generations. The procedure is performed on infants as young as eight days old. In the Jewish community, ritual circumcisions are conducted in accordance with medical protocols and in safe conditions; therefore, Jewish newborns can be circumcised within Jewish community facilities. Law 101 of 1989, which approved the agreement between Italy and the Italian Jewish communities, recognized the conformity of Jewish circumcision practices with the principles of the Italian legal system.²⁰

Male circumcision, although not mentioned in the Quran and therefore not obligatory, is practised almost universally by Muslim males. Islam bases the practice on the seventeenth chapter of Genesis, the same biblical chapter referenced by Jews. For Muslims, circumcision is associated with cleanliness, purification, and self-discipline. It can be performed from shortly after birth up to around fifteen years of age. Unlike Jews, Muslims do not have an agreement with the Italian state, primarily due to the lack of a hierarchical clerical structure and

the absence of a single representative body for the different Muslim communities in Italy.^{20, 21}

No official data are available on the prevalence of ritual non-therapeutic circumcision in Italy. Some estimates can be derived from the numbers of migrants originating from certain African regions, as reported in the annual Immigration Reports of Caritas Italiana and the Migrantes Foundation. According to estimates from the Association of Doctors of Foreign Origin in Italy (Amsi) and the Community of the Arab World in Italy (Co-mai), approximately 11,000 children are circumcised each year, of which 6,000 occur in their countries of origin and 5,000 in Italy.²²

According to estimates, at least one-third of the 5,000 circumcisions performed in Italy occur outside National Health Service facilities, in clandestine settings such as private homes and other unregulated environments, often by non-medical personnel. This practice carries a high risk of complications (early or late) and can even result in the death of the child, as highlighted by several recent news reports.²³⁻²⁵

Ritual (confessional or cultural-religious) circumcision is permitted under Italian law and, in any case, must be performed by urologists or surgeons in a day-hospital setting. However, currently the Italian regional health system does not guarantee uniform access to non-therapeutic circumcision across the country. In most regions, the procedure is only available privately. The cost, ranging between 2,000 and 4,000 euros, can be prohibitive for immigrant families, which often leads them to rely on unskilled personnel in unhygienic conditions, thereby putting the lives of children at risk.^{26, 27}

Female genital mutilation

According to the World Health Organization (WHO), the term “genital mutilation” refers to “all practices involving partial or total removal of the external female genitalia or other alterations to the female genital organs, carried out for cultural or other non-therapeutic reasons”.²⁸

FGM is internationally recognised (by WHO, UNICEF, the UN, and almost all states, whether Western, African, or Middle Eastern) as a serious violation of women’s physical, mental, and moral integrity, and as a severe infringement of fundamental human rights, including the right to health, the right not to be subjected to cruel and degrading practices, physical and sexual integrity, and reproductive rights.²⁹

FGM is mainly practised among ethnic groups in North and sub-Saharan Africa, the Arabian Peninsula, and the Middle East, but it is also present in Europe and Italy as a result of immigration. Although the majority of countries where FGM is practised are predominantly Mus-

lim, the practice is also carried out by ethnic groups adhering to animist or Christian faiths.³⁰ The WHO estimates that approximately 250 million women have undergone genital mutilation, and about 3 million minors are at risk of undergoing it each year. In Italy, due to significant migration from countries with a high prevalence of FGM – such as Egypt, Nigeria, Ethiopia, and Senegal – the estimated number of women with FGM is around 80,000, of whom approximately 7,000 are minors (estimates for 2016 by the University of Milan-Bicocca).^{31, 32}

Italian law (Law No. 7 of 9 January 2006) is particularly strict and provides for imprisonment of 4 to 12 years for anyone who performs FGM, even if the operation is carried out abroad on an Italian citizen or a foreign resident in Italy. The penalty is increased by one third if the victim is a minor, and if the procedure is performed by medical personnel, it entails disbarment and suspension from professional practice. As a prosecutable crime, Article 6 of the law also imposes an obligation on healthcare personnel to report cases to the competent authorities. In application of Law 7/2006, guidelines for healthcare personnel³³ have been issued to implement prevention strategies, provide healthcare assistance, and ensure rehabilitation for women and girls who have undergone FGM.

Unfortunately, this important tool for combating FGM remains largely unknown to most health workers, who also receive insufficient training on the topic during medical school and postgraduate residency programs in gynecology and obstetrics. It should be noted that having undergone FGM, if properly certified, can be useful for refugee status.³⁴

As emphasized in the guidelines,³³ healthcare workers in the National Health Service should have a basic understanding of FGM (including the associated health, anthropological, and sociological aspects) in order to identify girls at risk and implement preventive measures. Moreover, the proper documentation of FGM in pregnant women can represent a first step toward protecting newborn girls and women. The subsequent communication of this information to the neonatologist, and then to the pediatrician, allows ongoing monitoring of the family, which is essential to prevent the practice from being repeated on the next generation of girls.

Conclusion

As established by the Constitution, the role of our health system is to guarantee all individuals within the national territory the right to healthcare and full access to the services provided. One of the main challenges for the NHS is to address social and health inequalities, which increasingly affect broader segments of the population, both Italian and foreign.

In Italy, as in other transit and destination countries, barriers such as language and cultural differences hinder the ability of healthcare facilities to provide adequate care to foreign patients and complicate interactions with healthcare professionals. Among these barriers, gender plays a significant role, as it is shaped by the culture and religious beliefs of individuals and can influence healthcare in multiple ways.

Culture and religion contribute to the construction of gender roles in every population. Each individual carries with them a set of beliefs, ways of thinking, traditions, and cultural legacies. In the host country, faith and culture assume an important identity function and serve as strong instruments of belonging and cohesion for members of different communities.

Healthcare professionals inevitably encounter a range of cultural and religious models that may be unfamiliar to them, including rules established by different religions regarding various aspects of life – such as sexuality and procreation, as well as concepts of gender identity – and the need to intervene to counter traditional practices that are illegal, such as FGM, or dangerous, such as “home-made” ritual male circumcisions. A lack of understanding of both the spiritual and cultural frameworks of immigrant patients can lead to misunderstandings and, in some cases, further discrimination by healthcare providers, thereby complicating access to care and undermining trust in health services.

Awareness of the cultural and religious specificities of patients, and of the challenges these pose to healthcare provision, can help define strategies and tools to

prevent and overcome discrimination and ensure that adequate care is delivered to all, regardless of citizenship or cultural and religious background.

For example, simply being aware of the regions of the world where FGM or ritual circumcision are most prevalent can contribute to prevention, as well as to the identification, treatment, and rehabilitation of individuals seeking services from our health system.

These considerations apply to Italy but also to other transit and destination countries. Indeed, despite the improvement of conceptualization and the increasing of academic production on the topic, limited progress has been made towards a comprehensive implementation of migrant and culturally sensitive healthcare in Europe over the last 20 years.³⁵ To be noted that Europe hosts the largest number of international migrants worldwide (86.7 million)³⁶ and that the increasing workforce demand for aging population as well as conflicts and climate change (i.e., in Africa and Middle East) will reasonably increase those numbers.

The complexity described above spurs our national and regional health systems to make additional efforts to ensure health services offered be meaningful and effective for immigrants. Brochures, multilingual material and other tools informing immigrants about their rights in health, how the NHS works, how to access it, prevention campaigns involving the territory, places of worship and religious leaders, and the presence of cultural mediators in healthcare services could certainly facilitate access to care. Re-proposing and reinforcing the central role of the “Consultori” (medical advisory centres), by increasing their number and capacity with multidisciplinary and multiprofessional teams, could help to take care of the complex needs of victims of gender violence (such as FGM and others) and discrimination.

Above all, targeted training courses for all socio-healthcare personnel are highly needed to respond to the changes in Italian society, allowing NHS to meet its universalistic goal and deliver effective, personalized and humanized care.

Key messages

- The principles of the Italian National Health Service, which emphasize that access to comprehensive healthcare is a fundamental right of every individual, call for the identification and removal of barriers that foreigners living in Italy may encounter when seeking care.
- Among barriers, the literature highlights that culture, religion, and gender – shaped by the interplay between cultural and religious norms – significantly influence health-seeking behaviours and the acceptability of health services, often leading to their underuse, even when services are provided free of charge. Additionally, potentially harmful practices, such as female genital mutilation and unsafe ritual circumcision, are embedded within certain cultural and religious norms.
- The Italian health system, as well as healthcare services in other transit and destination countries, must strengthen culturally competent approaches by investing in healthcare worker training, cultural mediation, prevention of harmful practices, and the development of inclusive informational tools to ensure equitable, effective, and rights-based care for immigrant population.

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Correspondence to:

Claudio Giovannini

Center for Global Health Research and Studies

Università Cattolica del Sacro Cuore

Largo Francesco Vito 1

00168 Rome, Italy

Email: clagiovn@gmail.com